Rev. 7/07

QUARTERLY CONTRACT MONITORING REPORT (QCMR)
SUPPORTIVE HOUSING PROGRAM

USTF PROJECT CODE: _____

NAME OF AGENCY: _____

NAME OF PROGRAM: _____

PERSON COMPLETING FORM, ***inc. phone #*** _____

DATE SUBMITTED: _____

REPORTING QUARTER
(Check One)

JULY 1 to SEPTEMBER 30	1
OCTOBER 1 to DECEMBER 31	2
JANUARY 1 to MARCH 31	3
APRIL 1 to JUNE 30	4

Check Agency Reporting Quarter

1	2	3	4

A. Current Contracted Capacity — A.

1. Beginning Active Caseload (Carry-over from last quarter already Housed) — 1.

2. Number of New Enrollees to Program Element During this Quarter ***(Placed in Housing)*** — 2.

3. Number of Enrollees who were terminated from Supportive Housing This Quarter — 3.

3a. Number of clients/reasons for termination:

_____ No longer require Supportive Housing Services

_____ Returned to Supervised Housing

_____ Lost to Contact

_____ Hospitalized more than six months

_____ Moved out of Catchment Area

_____ Evicted

_____ Deceased

_____ Jailed

_____ Other

4. Ending Active Caseload ***(Last Day of Quarter)*** — 4.

Of the ending caseload how many individuals are:

4a. Medicaid/Familycare enrolled — 4a.

4b. Non-Medicaid/Familycare enrolled — 4b.

5. Clients enrolled in SH Services that were referred from the following this quarter:

5a. State/County Hospitals — 5a.

5b. Short Term Care Facility — 5b.

5c. Other inpatient settings (i.e., Voluntary) — 5c.

5d. Level A+, A, B, C, Family Care Supervised Housing — 5d.

5e. "Other Locations" (i.e. family, homeless, Boarding Home, Shelter, etc.) — 5e.